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Review

Forensic examination of the mentally disabled sexual abuse complainant

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ABSTRACT

Individuals who have mental disabilities are more vulnerable to sexual abuse than the general population and even less likely to report the offence. Furthermore they face greater barriers if they wish to seek help, support or prosecution. Where abuse is alleged or suspected, a complainant with a mental disability will often have the capacity to decide whether they wish to undergo intimate forensic examination. However, in cases where the individual truly lacks capacity it must be decided on an case to case basis without assumption or preconception whether such an examination is truly in their best interests. This aim of this review is to discuss sexual offences against adults with mental disabilities and the identification and management of these individuals.

1. Introduction

Rape and sexual abuse are highly prevalent international issues. Within the UK it is estimated that there are approximately 270 rapes a day.[1] Furthermore, 9.7–25% of women[2,3] and 6% of men[4] will experience some form of sexual abuse within their lifetime. The Sexual Offences Act (2003) differentiates sexual offences into 3 categories:

- **Rape**: when a person, A, intentionally penetrates another person, B's, mouth, anus or vagina with his penis without B's consent or reasonable belief that B consents.
- **Assault by penetration**: when A intentionally inserts a body part or anything else into B's mouth, anus or vagina when the penetration is sexual without B's consent or reasonable belief that B consents.
- **Sexual assault**: when A touches B in a sexual manner without B's consent or reasonable belief that B consents.

In the majority of sexual offences the perpetrator is known to the victim and is most commonly a current or ex-partner.[3] Many victims are repeatedly assaulted by the same perpetrator in a cycle of abuse from which it can be very hard to break free.

It is recognised that people with disabilities of any kind are more likely to become victims of sexual abuse than the general population and face greater difficulties seeking help, support or prosecution. People with mental disabilities are especially vulnerable yet often overlooked.

2. Mental disabilities and sexual vulnerability

Several studies, with statistically variable results, have been conducted looking at the extent of sexual offences against people with mental disabilities. It has consistently and repeatedly been shown that people with mental disabilities are more likely to be victims of sexual violence than those without.

- 49% people with intellectual disabilities experience 10 or more sexually abusive episodes in their lives.[5]
- Men with disabilities are twice as likely to be victims of sexual violence as men without disabilities.[6]
- >90% of people with developmental disabilities will experience physical or sexual abuse at some point in their life.[5]
- >70% female psychiatric in-patients and 80% of those in secure settings have experienced physical or sexual abuse.[7]

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The reasons for these alarming statistics are multi-factorial. Individuals with severe mental disabilities may not understand what is happening or have the communication skills necessary to report the abuse. People with a milder disability may realise they are being abused but may not understand that it is against the law and they have the right to say no. Furthermore, many people with mental disabilities may be socially isolated and reliant on an authority figure (i.e. family or carer) whose actions they may not question.

Sexual vulnerability is compounded when the abuser is the main carer as the carer has an increased level of control over the victim which may be used as part of the abusive cycle, preventing the victim from seeking help elsewhere. This is an issue for people with physical as well as mental disabilities and there are multiple accounts of demands for sex in return for the provision of care.[8]

It is often mistakenly assumed that people with mental disabilities are sexually inactive, which in combination with the physical, communicative or intellectual difficulties associated with certain mental disabilities can result in people with disabilities being perceived as powerless and an 'easy target' for abuse. Additionally, some people with certain disabilities may be more likely to give and receive affection, which may be falsely interpreted as sexual encouragement.

3. Mental disabilities and disclosure of abuse

It is known that sexual offences are severely under-reported in general, however this phenomenon is compounded in the mentally disabled population. In fact only 3% of sexual abuse cases involving people with developmental disabilities are ever reported.[5] This is most likely due to a combination of communicative difficulties; problems obtaining details of available support services; lack of abuse perception; fear they won't be believed and the control their abuser often has on their lives. Additionally, when a report is attempted, their disability may mean that the police do not view their statement as credible.[9]

Should a complainant of sexual abuse (or their carer) wish to seek help the main options are to go to the police who will refer them to a forensic examiner or, if available in their local area, to a Sexual Assault Referral Centre (to which they may also self-refer) where an integrated service of medical care, legal advice, forensic examination and counselling services are available. There are also numerous charities that provide anonymous support and counselling for victims of rape and sexual assault.

If a complainant of sexual abuse wishes to pursue prosecution of their alleged assailant the prosecution must prove that:

1. The sexual act occurred.
2. That the sexual act was not consensual (and that the accused did not have reasonable belief that the complainant consented).

In some cases sexual activity can be established by analysis of foreign secretions on the clothes of one or both parties involved or from any secretions, pubic hairs or other evidence collected at the crime scene. However, this material may not be available or may be insufficient to identify and detain the alleged assailant, in which case a forensic examination may be necessary. Note that whilst foreign secretions may indicate the sexual act occurred, the prosecution must still prove the absence of consent.

4. Capacity, consent & examination

In order to conduct a forensic examination the physician must obtain informed consent. In accordance with the Mental Capacity Act, 2005 for England and Wales, adults over the age of 16 are assumed to have the capacity to consent unless they have a disturbance or impairment of the mind or brain which will prevent them from making the decision in question within the necessary timeframe. In order to make the decision, the person must be able to:

1. Understand the information relevant to the decision.
2. Retain that information.
3. Use or weigh that information as part of the decision making process.
4. Communicate their decision (whether by talking, using sign language or by any other means).

Regardless of the level of disability, every complainant must be given as much support as possible from both the forensic physician and other relevant health professionals to enable them to have the capacity to consent. Capacity must always be judged on an individual basis as with the correct support a person whose diagnosis may suggest they would lack capacity may in fact be competent to make their own decision.

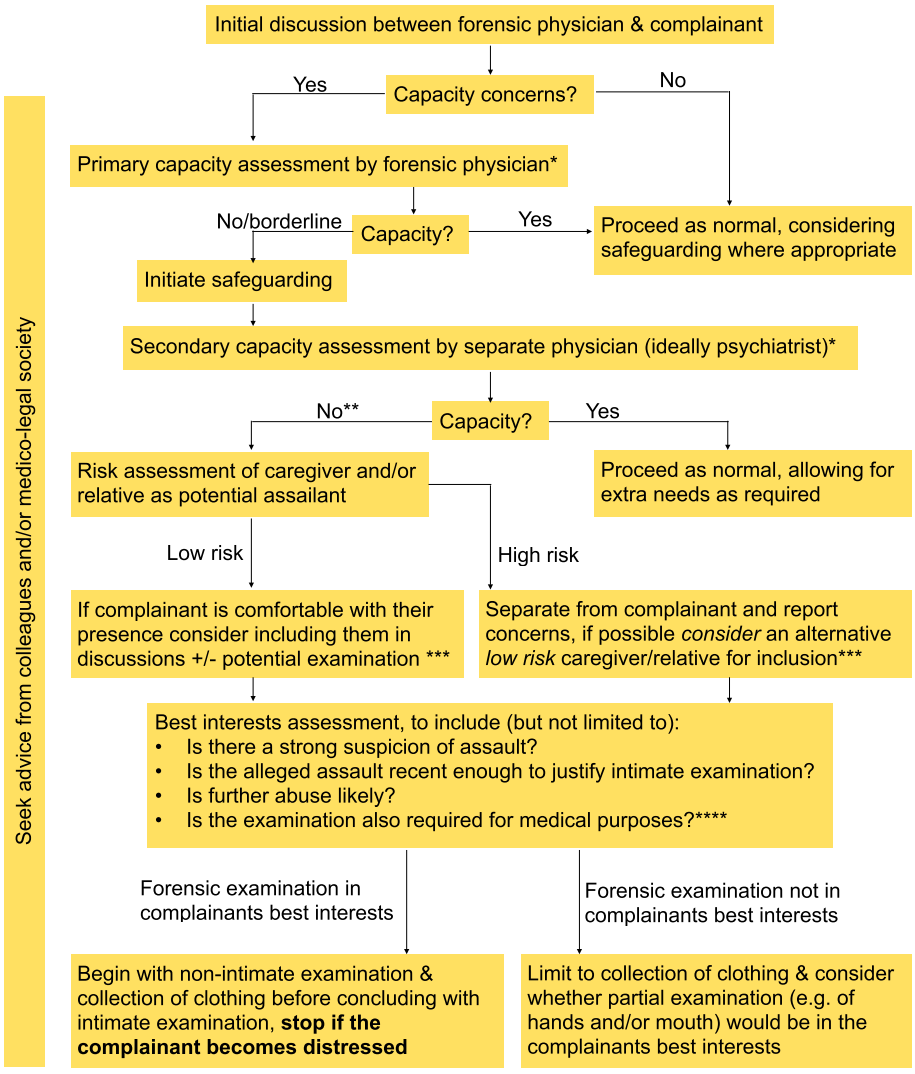
There are multiple tools available to aid the assessment of capacity, of which the MacArthur Competence Assessment Tool for Treatment (MacCAT-T) has the highest inter-user reliability ($\kappa > 0.8$).[10–12] The MacCAT-T is a semi-structured interview that takes approximately 15–30 minutes. It guides a clinician and patient (or in this case complainant) through a series of information disclosures whilst evaluating the four aspects of decision making capability deemed necessary for capacity under the Mental Capacity Act, 2005.

However, all capacity assessment tools have their limitations. The MacCAT-T for example requires specific training and lacks a predetermined cut-off separating capacity and incapacity.[11] This should not be prohibitive to its use as it was designed as an aid to capacity assessment rather than as a stand-alone tool but it does highlight the value of experience in such difficult cases. Consequently, when capacity is in question or the complainant is believed to lack capacity it is advisable to seek a second opinion, ideally from a psychiatrist with experience of complex capacity judgements (see Fig. 1).

If somebody is deemed to lack capacity, the first thing to determine is whether they are likely to regain capacity and if so when that is likely to be. Individuals with mental disabilities may have fluctuating capacity and if this is the case it may be possible to wait until they are more competent. In addition to mental disability, other factors such as alcohol, alcohol withdrawal, substances, substance withdrawal and serious injury (e.g. lack of consciousness) as well any fatigue, stress, anxiety or pain caused by the assault may also cause temporarily decreased capacity. It is important to note however that a delay may adversely affect their medical care and result in a loss of forensic material, potentially compromising the identification and apprehension of the alleged assailant.[13]

5. Sexual abuse complainants who lack capacity

During a forensic examination, the physician must decide which samples are relevant to the case from the complainant's account of the alleged assault and determine which will be of the greatest forensic value. As part of the process swabs are normally taken around and inside any orifice that was involved in the alleged assault. This can be distressing to any complainant and especially so to those who have been sexually abused and have not actively decided to undergo the examination. Therefore, whilst a decision can be made on behalf of a complainant lacking in capacity it must be in the best interests of the complainant and be the least restrictive option in terms of the complainant's rights, freedom and



* Assessment should include any communication aids required and may be conducted at an advantageous time of day if needed.

** No capacity and unlikely to gain/regain capacity. If capacity loss is likely temporary consider waiting for capacity to return before proceeding unless this is not in the complainant's best interests.

*** The presence of someone known to the complainant can be valuable to help with communication and reassurance. However, it is important to remember that not only is the alleged abuser likely known to the complainant but that the complainant may not wish to disclose the alleged assault.

**** Such as testing for sexually transmitted infections.

Fig. 1. Suggested initial management of the sexual abuse complainant with borderline/absent capacity.

quality of life. Due to the distressing nature of this examination, it is only considered justifiable when there is strong supporting evidence of serious sexual assault and must be stopped if the complainant is non-compliant.[13]

This is not a decision to be taken lightly and it is advisable to consult colleagues and to take medico-legal advice when faced with this situation. The likelihood of recovering DNA and/or other evidence should be considered as part of the decision making process using the timeframes for persistence data[14] and factors such as how much the complainant has washed since the alleged assault. However, even after the timeframes for persistence data have passed, examination may still reveal forensic evidence in the form of injuries or even scars. On the other hand, in some cases, samples from the crime scene, clothing or underwear may be more likely to provide evidential results.

If such evidence is unavailable and the alleged assault was recent enough to obtain forensically valuable information from the examination, it must be determined if this is in the complaint's best interests. In order to do this, the physician should encourage participation from the complainant and try to identify all the relevant circumstances that the complainant would take into account were they deciding for themselves. The physician should also consider consulting people close to the complainant or, if relevant and available, an attorney, deputy or Independent Mental Capacity Advocate to help determine the complaint's past and present beliefs, values, wishes and feelings as these should be factors in the

decision. However, a lack of privacy and confidentiality often forms part of the abuse dynamic for victims with disabilities[15] and as the abuser is likely to be known to the complainant, great care should be taken in deciding who to consult.

When considering what constitutes best interests it must be remembered that the forensic examination has a dual purpose. In addition to the collection of evidence the forensic physician may screen for sexually transmitted infections, assess and treat injuries, provide emergency contraception and/or post exposure prophylaxis for HIV and Hepatitis B when indicated. Therefore even when the examination is unlikely to be useful from an evidentiary perspective, it may still be in the complainant's best interests to be assessed for therapeutic reasons.

If it is decided that forensic examination is in the complainant's overall best interests it should be ascertained if the consultant usually responsible for the complainant's medical care has any objections to it being undertaken and if possible someone who is known and trusted by the complainant should be present during the examination to facilitate communication.[13]

Whichever decision is reached, all of the steps involved in determining capacity and the complainant's best interests must be clearly documented in the medical records and the examining physician should be prepared to justify their decision in court.

6. Global folk beliefs

Stories of virgin cleansing (the folk belief that individuals with sexually transmitted infections can cure themselves by transferring the disease to a virgin through intercourse) have attracted widespread media attention when used as a 'justification' by a minority of HIV/AIDS patients for the rape of young children and even babies. The practice is believed to have originated with syphilis and gonorrhoea in 16th century Europe[16] and whilst the modern day prevalence is unclear there are accounts of virgin cleansing in Europe, Asia, sub-Saharan Africa and the Americas.[17]

In addition to the increased vulnerabilities described above, individuals with disabilities are often incorrectly assumed to be virgins and can easily become victims of this type of sexual abuse. Unfortunately there are numerous reports of blind, deaf, physically & mentally disabled individuals being raped due to this belief. Of the 21 countries reviewed by the 'Global survey on HIV/AIDS and disability', the rape of individuals with disabilities in association with HIV/AIDS was reported in 14 countries. Worryingly, in 12 of the countries where this phenomenon was identified, it is believed that this type of rape has markedly increased in recent years.[18]

7. Discussion

It is difficult to decide how to proceed when sexual abuse is suspected in an individual who lacks the capacity to make their own medical decisions. Whilst there are guidelines on taking consent from patients who have been seriously assaulted[13] the justification for an examination varies with the circumstances of each complainant and each alleged assault, so must be judged on a case to case basis. It is standard to seek medico-legal advice for cases like these yet the inherent ambiguity of this decision means that the physician is still vulnerable to legal action. Examination without valid consent is battery, and breaches best practice guidelines, principles of autonomy and Human Rights. However, under UK law, no one can give medical consent on behalf of another adult unless they have been appointed as a deputy by the Court of Protection or hold a Lasting Power of Attorney (LPA). As LPAs can only be set up by someone who has the capacity to do so, they are not an option for someone who has always lacked capacity. Therefore, in cases such as these, it often the responsibility of the forensic physician to act in the complainant's best interests, or rather, what they judge to be the complainant's best interests. Whilst this works well for decisions based purely on an individual's healthcare needs, the forensic examination is sometimes, but not always, medically advantageous to the complainant.

When the complainant's medical needs can be met without the examination, the intrusive nature of the examination and the legal risks faced by the physician mean it may be easier to abstain from forensically examining sexual abuse complainants who cannot consent for themselves. However, this risks returning the complainant to a situation of continued sexual abuse that might have been prevented, harming not only the complainant but potentially missing an opportunity to protect future victims. In such circumstances it must be considered whether further disclosure regarding the abuse is in the complainant's best interests or necessary to protect others from a risk of serious harm. The latter is particularly relevant when the alleged assailant works with or has contact with other vulnerable people. The complainant's capacity to decide to disclose this information must be assessed separately from their capacity to consent to examination and, if lacking, GMC guidance regarding disclosures about patients who lack capacity to consent[19] should be followed.

A possible advantage of the difficulties in forensically examining complainants who lack capacity to consent is that the police and crime scene investigators are forced to thoroughly pursue every other possible route of substantiating the alleged assault, which acts as a safeguard protecting vulnerable people from a distressing procedure that may not result in any forensic evidence. However, this should not be allowed to prevent examinations that should be done in the complainant's best interests.

Therefore when a complainant lacks the capacity to consent it is necessary to take a broader perspective of what constitutes their best interests and consider their overall well being rather than focusing on the purely medical issues. This approach enables forensic examination to be justified when it is necessary, the complainant is cooperative and it is for their greater personal benefit.

8. Conclusions

Sexual abuse of people with mental disabilities is a highly prevalent yet sadly neglected issue. Regardless of disability status, women are more frequently sexually assaulted than men, therefore the sexual abuse of men with disabilities is especially overlooked. Individuals with mental disabilities have increased vulnerability to sexual abuse as they may not understand the situation or their rights, and on a global level they are at increased risk of being raped due to 'virgin cleansing' beliefs. Furthermore, the under reporting of sexual violence in the general population is amplified in people with mental disabilities as they may struggle to communicate the situation and seek help.

People with mental disabilities who do report sexual abuse face extra difficulties as their statement may not be viewed as credible and they may not have the capacity to consent or decline a forensic examination. If the complainant cannot give valid consent each case must be judged individually and without assumption. It may be easier to abstain from forensic examination than proceed, as evidence can often be collected from clothing and other sources. This protects vulnerable people from unnecessary distressing intimate examinations. However, when forensic examinations are necessary to prevent further abuse they should not be avoided if the complainant is cooperative. Therefore, whilst forensic physicians should be prepared to defend their decision in court, they must ensure the complainant's best interests are always at the heart of the decision making process.

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